

## **APPENDIX E**

### **NHDS Medical Abstract Form**

Form HDS-1

U.S. DEPARTMENT OF COMMERCE  
Economics and Statistics Administration  
U.S. CENSUS BUREAU  
ACTING AS COLLECTING AGENT FOR  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
NATIONAL CENTER FOR HEALTH STATISTICS

### A. PATIENT IDENTIFICATION

		Month		Day		Year	
1. Hospital number				–			–
2. HDS number							
3. Medical record number							
4. Date of admission				–			–
5. Date of discharge							
6. Residence ZIP Code							

<b>7. Date of birth</b> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">Month <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div></div> <div style="text-align: center;">Day <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div></div> <div style="text-align: center;">Year <div style="border: 1px solid black; width: 60px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div></div> </div>	<b>11. Race – Mark all that apply</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> 1 <input type="checkbox"/> White  2 <input type="checkbox"/> Black or African American  3 <input type="checkbox"/> American Indian or Alaska Native  4 <input type="checkbox"/> Asian  5 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander </div> <div style="width: 50%;"> 6 <input type="checkbox"/> Other – <i>Specify</i> <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div> 7 <input type="checkbox"/> Not stated </div> </div>
<b>8. Age – Complete only if date of birth not given</b> ..... <div style="display: flex; align-items: center;"> <div style="text-align: center; margin-right: 10px;">Units <div style="border: 1px solid black; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div></div> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> 1 <input type="checkbox"/> Years  2 <input type="checkbox"/> Months  3 <input type="checkbox"/> Days </div> </div>	<b>12. Marital status – Mark (X) one</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> 1 <input type="checkbox"/> Married  2 <input type="checkbox"/> Single </div> <div style="width: 33%;"> 3 <input type="checkbox"/> Widowed  4 <input type="checkbox"/> Divorced </div> <div style="width: 33%;"> 5 <input type="checkbox"/> Separated  6 <input type="checkbox"/> Not stated </div> </div>
<b>9. Sex – Mark (X) one</b> 1 <input type="checkbox"/> Male      2 <input type="checkbox"/> Female      3 <input type="checkbox"/> Not stated	<b>10. Ethnicity – Mark (X) one</b> 1 <input type="checkbox"/> Hispanic or Latino      2 <input type="checkbox"/> Not Hispanic or Latino      3 <input type="checkbox"/> Not stated

<p><b>13. Type of Admission – Mark (X) one</b></p> <div style="display: flex; justify-content: space-between;"> <div>1 <input type="checkbox"/> Emergency</div> <div>3 <input type="checkbox"/> Elective</div> <div>5 <input type="checkbox"/> Items not available/ unknown</div> </div> <div style="display: flex; justify-content: space-between;"> <div>2 <input type="checkbox"/> Urgent</div> <div>4 <input type="checkbox"/> Newborn</div> </div> <p><b>14. Source of Admission – Mark (X) one</b></p> <div style="display: flex; justify-content: space-between;"> <div>1 <input type="checkbox"/> Physician referral</div> <div>7 <input type="checkbox"/> Emergency room</div> </div> <div style="display: flex; justify-content: space-between;"> <div>2 <input type="checkbox"/> Clinical referral</div> <div>8 <input type="checkbox"/> Court/Law enforcement</div> </div> <div style="display: flex; justify-content: space-between;"> <div>3 <input type="checkbox"/> HMO referral</div> <div>9 <input type="checkbox"/> Other – <i>Specify</i> <span style="border: 1px solid black; display: inline-block; width: 150px; height: 1.2em; vertical-align: middle;"></span></div> </div> <div style="display: flex; justify-content: space-between;"> <div>4 <input type="checkbox"/> Transfer from a hospital</div> </div> <div style="display: flex; justify-content: space-between;"> <div>5 <input type="checkbox"/> Transfer from SNF</div> </div> <div style="display: flex; justify-content: space-between;"> <div>6 <input type="checkbox"/> Transfer from other health facility</div> <div>10 <input type="checkbox"/> Item not available</div> </div> <p><b>15. Status/Disposition of patient – Mark (X) appropriate box(es)</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; text-align: left;">Status</th> <th style="width: 70%; text-align: left;">Disposition</th> </tr> </thead> <tbody> <tr> <td>1 <input type="checkbox"/> Alive</td> <td> <div style="display: flex; justify-content: space-between;"> <div>→ a. <input type="checkbox"/> Routine discharge/discharged home</div> <div>b. <input type="checkbox"/> Left against medical advice</div> </div> <div style="display: flex; justify-content: space-between;"> <div>c. <input type="checkbox"/> Discharged, transferred to another short-term hospital</div> <div>d. <input type="checkbox"/> Discharged, transferred to long-term care institution</div> </div> <div>e. <input type="checkbox"/> Other disposition/not stated</div> </td> </tr> <tr> <td>2 <input type="checkbox"/> Died</td> <td></td> </tr> <tr> <td>3 <input type="checkbox"/> Status not stated</td> <td></td> </tr> </tbody> </table>	Status	Disposition	1 <input type="checkbox"/> Alive	<div style="display: flex; justify-content: space-between;"> <div>→ a. <input type="checkbox"/> Routine discharge/discharged home</div> <div>b. <input type="checkbox"/> Left against medical advice</div> </div> <div style="display: flex; justify-content: space-between;"> <div>c. <input type="checkbox"/> Discharged, transferred to another short-term hospital</div> <div>d. <input type="checkbox"/> Discharged, transferred to long-term care institution</div> </div> <div>e. <input type="checkbox"/> Other disposition/not stated</div>	2 <input type="checkbox"/> Died		3 <input type="checkbox"/> Status not stated		<p><b>16. 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**D. MEDICAL INFORMATION****17. Final Diagnoses (including E-code diagnoses) (Enter ICD-9-CM codes as well as narrative if available)**

Principal: \_\_\_\_\_

Other/additional: \_\_\_\_\_

**18. Surgical and Diagnostic Procedures (Enter ICD-9-CM codes as well as narrative if available)**

Date of procedure(s)

Month

Day

Year

Principal: \_\_\_\_\_

Other/additional: \_\_\_\_\_

☐ NONE

Completed by

Date